

## Adult Day Health Care

ADHC facilities provide temporary or permanent daytime care for aged or infirm persons, age 18 years and older. ADHC consists of structured, comprehensive and continually supervised components provided in a protective setting. Halfway houses and services for recovering alcoholics or drug abusers are not a part of ADHC services.

For Waiver Adult Day Care Programs, refer to [Billing Guide for Provider Type 48 – Home and Community Based Waiver for the Frail Elderly](#). The Aging and Disability Services Division (ADSD) must approve recipients to receive adult day care services on the Home and Community Based Waiver for the Frail Elderly (also known as “CHIP”).

### Covered services

ADHC covered services include nursing services, restorative therapy, nutritional assessment and planning, social and recreational activities, training in activities of daily living, supervision and case management.

For additional information and policies regarding ADHC, refer to the Nevada Medicaid Services Manual, Chapter 1800 online at <http://dhcfp.nv.gov>.

### Prior authorization requirements

All ADHC services require prior authorization. Prior authorization requests must identify (1) that the recipient meets a nursing facility level of care, (2) at least one rehabilitation goal, (3) which medical and non-medical services are to be provided and (4) the frequency and duration of the requested services.

To request prior authorization for services, complete and fax to Hewlett Packard Enterprise the Adult Day Health Care Prior Authorization Request form (FA-17) and a copy of the physician's order. Form FA-17 is available online at <https://www.medicaid.nv.gov>

There are four types of ADHC prior authorization requests: Initial, Continuing, Interim and Retro-Eligibility.

An *initial* prior authorization request must be submitted at least five days before providing services to a Medicaid recipient for the first time. Providers will not be paid if services are provided before a Prior Authorization Number is issued except in the case of a *retro-eligibility* authorization (see below). Contact Hewlett Packard Enterprise if a prior authorization request is submitted and no response is received after five business days. To request authorization for initial services, check the box next to *Initial/New* in the *Request Type* field on form FA-17.

A *continuing* prior authorization request must be submitted to authorize ongoing services *before* the previous authorization period expires. No payment will be made when services are provided without authorization. This includes any time lapse between authorized periods. To request authorization for continuing services, check the box next to *Continuing Services* in the *Request Type* field on form FA-17.

An *interim* prior authorization request must be submitted to request a change in frequency or duration of services. To request an interim authorization, check the box next to *Interim* in the *Request Type* field on form FA-17.

A *retro-eligibility* prior authorization may be requested if a recipient becomes eligible for Medicaid after services have been provided. *Retro-eligibility* requests must be submitted within 90 days from the date that the recipient's Medicaid eligibility was determined. To request a *retro-eligibility* authorization, check the box next to *Retro-Eligibility* in the *Request Type* field on form FA-17.

## Adult Day Health Care

Before submitting your claim, you must receive approval from Hewlett Packard Enterprise. Prior authorization approvals from Hewlett Packard Enterprise are in writing and list a Prior Authorization Number and the dates and code(s) that have been authorized.

When submitting your claim to Hewlett Packard Enterprise, your Prior Authorization Number must be entered in **Field 23** on the CMS-1500 claim form. Claims are payable only when the dates of service shown on the claim form are within the dates shown on your approved prior authorization.

### Special billing instructions

Do not add dashes, spaces or other symbols between or in front of any of the following numbers on your claim form: the National Provider Identifier (10 digits), the Recipient ID (11 digits) or the Prior Authorization Number (11 digits).

Submit claims on a monthly basis. Do not include more than one month of services on one claim form.

Omit the dates from your claim that a recipient is in another medical facility during a billing period by using separate claim lines. If a recipient is in any other medical facility (e.g., hospital, nursing facility, ICF/MR) during the same service period indicated on the ADHC claim form, the ADHC claim cannot be paid.

The *From* date of service (**Field 24A**) should reflect the first day of service in the given month. The *To* date of service should reflect the last day of service in the given date segment. Use more than one claim line if there are multiple date segments in one month.

Examples:

- 1 If a prior authorization request is approved from the 1st through the 15th of the month and another prior authorization request is approved for the same recipient from the 16th and through the 31st of the month, you must use a separate claim line or a separate claim form for each date segment, even if the Prior Authorization Number is the same for both segments.
- 2 If Hewlett Packard Enterprise approves a prior authorization request for the entire month of June, but the recipient does not attend the ADHC facility because they are hospitalized or institutionalized from the 9th through the 12th of that month, use two claim lines to show two date segments as shown below. Enter the Prior Authorization Number in **Field 23** only once.

Be sure that your *From* and *To* dates are within the dates shown on your written prior authorization approval from Hewlett Packard Enterprise.

HCPCS code S5100 is used to bill all ADHC services (S5100 - Day care services, adult; per 15 minutes).

- One (1) unit = 15 minutes.
- The maximum number of billable units per day is 24.

Effective with claims processed on or after December 21, 2015, provider type 39 is no longer required to submit an EOB or denial letter from the other health care (OHC) coverage provider.